PRINTED: 09/27/2011
FORM APPROVED
OMB NO. 0038 0391

CENTERS FO	R MEDICARE & MEDIC	CAID SERVICES				ON	AB NO. 0938-0391
STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	ULTIPLE CC	ONSTRUCTION	(X3) DATE SURVEY		
AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155003		IDENTIFICATION NUMBER:	A. BUILDING 01			COMPLETED	
		B. WIN			09/09/2	2011	
			P		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF	PROVIDER OR SUPPLIE	R		1	OVIDENT DR		
MASON	HEALTH CARE CE	ENTER		1	AW, IN46580		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECT	TON	(X5)
PREFIX	,	NCY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO		COMPLETION
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION)	_	TAG	DEFICIENCY)		DATE
K0000							
	Δ Life Safety C	ode Recertification	K	0000			
	I -	nsure Survey was	11	0000			
	1	•					
	· ·	the Indiana State					
	Department of						
	accordance wi	th 42 CFR 483.70(a).					
	Survey Date: 09/09/11						
	Facility Number: 000003						
	Provider Number: 155003						
	AIM Number: 100290600						
	All Nulliber.	100230000					
	Surveyor: Amy Kelley, Life Safety						
	Code Specialist						
	At this Life Saf	ety Code survey,					
	Mason Health Care Center was						
	found not in compliance with						
	1	for Participation in					
	I -						
	Medicare/Med						
	I	O(a), Life Safety					
	1	the 2000 edition of					
	the National Fi						
	Association (N	FPA) 101, Life Safety					
	Code (LSC) and	d 410 IAC 16.2. The					
	original buildii	ng consisting of the					
	1 -	halls and the center					
	1	yed with Chapter 19,					
	1	n Care Occupancies.					
		. Im a a companion					
	1		1		I		1

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

This one story facility was

Any defiency statement ending with an asterisk (\*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

FORM CMS-2567(02-99) Previous Versions Obsolete Event ID: 4W4A21

Facility ID:

000003

TITLE

If continuation sheet

(X6) DATE

PRINTED: 09/27/2011 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CO	ONSTRUCTION	(X3) DATE SURVEY		
AND PLAN OF CORRECTION		IDENTIFICATION NUMBER:	A. BUILDING 01		COMPLETED		
155003		B. WING	09/09/2011				
		<u> </u>		ADDRESS, CITY, STATE, ZIP CODE			
NAME OF PROVIDER OR SUPPLIER			900 PF	ROVIDENT DR			
	HEALTH CARE CEI		WARSAW, IN46580				
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIES  (EACH DEFICIENCY MUST BE PERCEDED BY FULL  DESCRIPTION OF LIST INFORMATION)		ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE	(X5)		
PREFIX TAG			PREFIX TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE COMPLETION DATE		
IAG	REGULATORY OR LSC IDENTIFYING INFORMATION)		IAG		DAIL		
		be of Type V (000)					
	construction ar	•					
	sprinklered. The facility has a fire						
	alarm system w						
		rridors, areas open					
	to the corridors						
		on the 400 wing.					
		a capacity of 110					
	and had a cens	us of 87 at the time					
	of this survey.						
	Quality Review by Robert Booher, Life Safety						
	Code Specialist-Me	dical Surveyor on 09/13/11.					
	The facility was found not in						
	compliance with the						
	I -						
	aforementioned regulatory requirements as evidenced by the						
	-	is evidenced by the					
	following:						
120070	Dortoble anges he	eating devices are prohibited	1				
K0070 SS=D		eating devices are prohibited occupancies, except in					
33-0		and employee areas where					
	_	nts of such devices do not					
	_	es F. (100 degrees C)					
	19.7.8	avation and	K0070	This Plan of Correction is	09/30/2011		
	Based on obser		IX0070	prepared and executed beca			
		acility failed to have		it is required by the provision	l l		
	a policy for the			State and Federal Law, and	l l		
	portable space			because Mason Health Care agrees with the allegations	;		
	-	dance with NFPA		contained there-in. Mason F	lealth		
	101, Section 19	9.7.8. This	1	Care maintains that each			
			1	1	ı		

## DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 09/27/2011 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155003		A. BUILDING 01			(X3) DATE SURVEY COMPLETED 09/09/2011		
NAME OF PROVIDER OR SUPPLIER  MASON HEALTH CARE CENTER			B. WING 09/09/2011  STREET ADDRESS, CITY, STATE, ZIP CODE 900 PROVIDENT DR WARSAW, IN46580				
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES  (EACH DEFICIENCY MUST BE PERCEDED BY FULL  REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)			Ē	(X5) COMPLETION DATE
K0000	deficient practi resident care a any staff in the Findings includ Based on obser Maintenance St 09/09/11 at 12 was a space he office located of The space heat but not use at the an interview wi Supervisor at the	ce is not in a rea but could affect MDS office.  e: vation with the upervisor on 2:56 p.m., there ater in the MDS on the 300 hall. er was plugged in this time. Based on th the Maintenance ne time of e facility does not			deficiency does not jeopardize health and safety of the reside nor is it of such character as limit our capability to render adequate care. Please let the POC response serve as the facilities Credible Allegation of Compliance 9/30/11. The fact has adopted a policy for the of portable space heaters in facility. The space heater identified has been reviewed the Maintenance Supervisor ensure it is compliant with the facility portable space heater policy. In addition, the Maintenance Supervisor has assessed the facility to ensure portable space heaters, if any are in compliance with the adopted policy. The Maintenance Supervisor conduct a review of portable space heaters every 6 month ensure continued compliance Results of the review will be reported to the Quality Assur Committee.	tents, to is of cility use the by to e re all y,	
	and State Licen	ode Recertification sure Survey was he Indiana State	K0000	)			

PRINTED: 09/27/2011 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION		NSTRUCTION	(X3) DATE SURVEY	
AND PLAN OF CORRECTION		IDENTIFICATION NUMBER:	A. BUILDING 02		02	COMPLETED	
		155003	B. WING			09/09/2011	
			B. WIIV		ADDRESS, CITY, STATE, ZIP CODE	<u> </u>	
NAME OF PROVIDER OR SUPPLIER					OVIDENT DR		
MASON HEALTH CARE CENTER				1	AW, IN46580		
(X4) ID		STATEMENT OF DEFICIENCIES		ID	REFIX PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE		(X5)
PREFIX	`	ICY MUST BE PERCEDED BY FULL		PREFIX			COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)	+	TAG	DEFICIENCY)		DATE
	Department of	Health in					
	accordance wit	th 42 CFR 483.70(a).					
	Survey Date: 0	09/09/11					
	Facility Numbe	r: 000003					
	Provider Numb						
	AIM Number:						
	All Number.	100230000					
	Survevor: Amv	Kelley, Life Safety					
	Code Specialist						
	Code Specialist						
	At this Life Safety Code survey,						
	Mason Health Care Center was						
	found in comp						
	· ·	for Participation in					
	Medicare/Medi	•					
	· ·						
	· ·	O(a), Life Safety					
		the 2000 edition of					
	the National Fi						
		FPA) 101, Life Safety					
	Code (LSC) and 410 IAC 16.2. The						
	2004 addition of the 400 Hall and						
	the Therapy room was surveyed						
	with Chapter 1	8, New Health Care					
	Occupancies.						
	This one story	facility was					
	determined to	be of Type V (000)					
	construction a	nd was fully					
		he facility has a fire					
	alarm system v						
	Ī -	rridors, areas open					
	l acrection in co	illuuls, aleas upell					

## DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 09/27/2011 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155003	(X2) M A. BUII B. WIN	LDING	ONSTRUCTION 02	(X3) DATE COMPI <b>09/09/2</b>	LETED
NAME OF PROVIDER OR SUPPLIER  MASON HEALTH CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE  900 PROVIDENT DR  WARSAW, IN46580				
(X4) ID PREFIX		MMARY STATEMENT OF DEFICIENCIES DEFICIENCY MUST BE PERCEDED BY FULL		ID PROVIDER'S PLAN OF CORI PREFIX (EACH CORRECTIVE ACTION SH		D BE	(X5) COMPLETION
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION)	TAG		CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	IE	DATE
	The facility has	s on the 400 wing. s a capacity of 110 sus of 87 at the time					

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

4W4A21 Facility ID:

D: 000003

If continuation sheet

Page 5 of 5